A WORKSHOP ON
"EFFECTIVE IMPLEMENTATION OF
NATIONAL HEALTH POLICY"

Held at
Indore on April 3-4, 1990

PROCEEDINGS & RECOMMENDATIONS

ORGANIZED BY:

M.P. Voluntary Health Association
&
Voluntary Health Association
In collaboration with:
Directorate of Health Services.

SPONSORED BY :

World Health Organization

FORWORD

At present it is becoming more and more clear that despite of all our efforts, a gap between real health needs of community and the health services is widening. This situation has been created by a convergence of several negative trends. Among them, the major trends are : highly centralised planning, hospital based disease oriented approach based on western model, almost an absence on inter sectoral co-ordination, failure to establish an effective management information system, commercialisation of medical and drug industry, and above all no inbuilt system of monitoring and evaluation, and hence no accountability. A net picture of the situation is that the demographic and health picture of the country still constitutes a cause for serious and urgent concern.

A promise to revolutionize the health care delivery system first came to us through the National Health Policy which was passed by the Parliament in 1982. However, during last eight years the policy document remained in files, and we only witnessed linear extension of all those negative trends of pre-policy period.

With a renewed hope we called upon government health functionaries and the representatives of voluntary agencies to examine the gaps between policy and implementation and suggest guidelines for a viable alternative. This workshop was held at Indore on April 3-4, 1990.

It is our privilege to present a report of the workshop before you. We sincerely hope that this will mark a beginning of a new era in our health care delivery system.

Raj Bhujbal
Executive Secretary.
M.P.Voluntary Health Association.

ACKNOWLEDGMENT

The success of the workshop could not have been achieved without pioneering efforts of VHAI Executive Director Mr. Alok Mukhopadhyay to initiate a national debate on the Health Policy. Our special thanks must go to Institute of Health Management, Pachod Director Dr.Ashok Dayalchand and IHMP Associate Director Dr.Manisha Khale for planning the workshop so innovatively and for creating a desired momentum during the workshop through highly informative speeches.

One of the special features of the workshop was an indepth participation of most government health functionaries of the division. They shared their experiences and discussed issues and strategies for meeting future needs. This was mainly because of a strong leadership and participation of joint Director Health Services Dr.C.S.Gandhe. We are grateful to him for his efforts.

During the workshop we were enlightened by the thoughts of our state level leaders in the field of health, the present Director of Medical Services Dr.K.L.Simlot, MGM Medical College Dean Dr.V.K.Agrawal, and ODA Project Director Dr.Inder Bhargav. We specially thank them for their guidance.

MP VHA Board Members and specially President Fr.Joseph Thayil, Secretary Sr.Anne Maria, Members Dr.Ramesh Nagrath and Dr.R.P.Dass deserve a special recognition for providing guidance and support throughout the planning and conducting of the workshop.

The excellent logistical supports was due to the hard work of MP VHA staff. Special mention must go to office secretary Mrs.Annamma Jose, Programme Officers Mrs.Pushpa Mahendra and Raksha Singh, and Accountant Mr.K.J.Thomas.

Finally, the acknowledgment would be incomplete without giving recognition to IHMP staff Ms.Nandita Kapadia for writing and editing the proceedings and recommendations.

Raj Bhujbal.
Executive Secretary. MP VHA.

DIVISIONAL LEVEL WORKSHOP ON NATIONAL HEALTH POLICY

April 3-4 1990
Indore, Madhya Pradesh

A workshop on National Health Policy (NHP) for Madhya Pradesh's Indore Division (covering 5 districts) was held at Indore on April 3-4, 1990. The workshop was for district-level health functionaries. It aimed to promote the interpretation of NHP and its relevance at the district level. Therefore the objectives of the Workshop were:

a. To identify gaps the between NHP and its implementation;
b. To make recommendations for the effective implementation of the policy.

The workshop was attended by 61 participants (refer Appendix I for the list of the participants).

The participants included Chief Medical Officers, District Health Officers, District Medical Officers of each district, Joint Director of Health Services, Divisional Level Media Officer, Principal and other functionaries of District Health and Family Welfare Training School, Representatives of PSM Department of Medical College, Representatives of Danida, Executive Secretary of MPVHA and the Representatives of Voluntary Health Organisation of the Division.

From left
1. Dr.C.S.Gandhe(Joint Director health Services)
2. Dr.Ashok Dayalchand (Director, IHMP)
3. Dr.K.L.Simlot (Director Medical Services)
4. Dr.J.S.Mahashabde (VHAI Vice-President)
5. Dr.V.K.Agrawal (Dean, M.G.M.Medical College, Indore)
6. Dr.M.C.Mittal (Retd.Professor of Community Medicine)
7. Dr.Inder Bhargav (ODA Project Director)

Dr. A Dyalchand, Director, Institute of Health Management, Pachod (IHMP) and Ms Manisha Khale, Associate Director, IHMP were the resource persons for the workshop.

Background

The National Health Policy document was prepared in 1982. However, considerable gaps between the policy and its implementation were evident. In order to identify and bridge these gaps, Voluntary Health Association of India (VHAI) in 1987, decided to organize State-level National Health Policy Workshops for the entire country. VHAI approached the government of India who to gave approval to have state-level workshops followed by divisional level workshops to disseminate the NHP. The NHP workshops are sponsored by the World Health Organisation.

The Madhya Pradesh Voluntary Health Association (MPVHA) organised a state-level workshop at Bhopal in May, 1988. It was then decided to organize three subsequent divisional level workshops.

Preparatory Phase:

The workshop programme was planned by Mr. R. Bhujbal, Executive Secretary, MPVHA and Dr. C.S. Gandhe, Joint Director, Health Services in consultation with the resource persons. A detailed programme was prepared which focussed on active involvement from the participants (refer Appendix 2 for workshop programme).

Inaugural Session:

The National Health Policy workshop was inaugurated by Dr. V.K. Agrawal, Dean, Mahatma Gandhi Medical College, Indore. The session was presided over by Dr. C.S. Gandhe, Joint Director, Health Services. Dr. Gandhe welcomed the participants and briefly stated the objectives of the workshop. He expressed a concern over a growing gap between the health needs of the community and the services provided to them. He called upon the participants to examine the present achievements of health care services in the light of National Health Policy.

Keynote Address:

In his keynote address, Dr. Dyalchand addressed several issues related to the National Health Policy. He stressed the need to examine all aspects of the policy from budgetary allocations to constraints in implementation. He said that the proportionate increase in the health budget has successively decreased with each Five Year Plan. As a result, in the Seventh Five Year Plan, health had only 1.8 per cent of the total budgetary outlay. Of equal concern is the complete lack of debate or demand from the health sector on this very important issue.

Dr. Dyalchand stated that the planning process was static because of its target based approach has resulted in centralised, top-down planning. This type of planning is not sensitive to varying local conditions and needs. He cited the example of the Universal Immunization Programme which was uniformly introduced in the entire country in 1985 not taking into account the obviously varying health infrastructure in different parts of the country. Planning therefore is based on averages (which provide a generalized central tendency) and not on the basis of variation.

He then outlined the discrepancies in Government reports and actual coverage. He cited the ICMR study (1988) on Maternal Care which shows all India ANC coverage for rural areas to be as low as 20-25 per cent. Whereas official figures show very high coverage. At the same time, he said that there is need to examine the reasons for the success of a state like Goa which has enviable health indices of CBR - 18.24 per 1000 and IMR 24 per 1000 live births.

Given the overview of the existing situation vis a vis NHP, Dr Dyalchand put forward the various levels of concern in this area. They are:

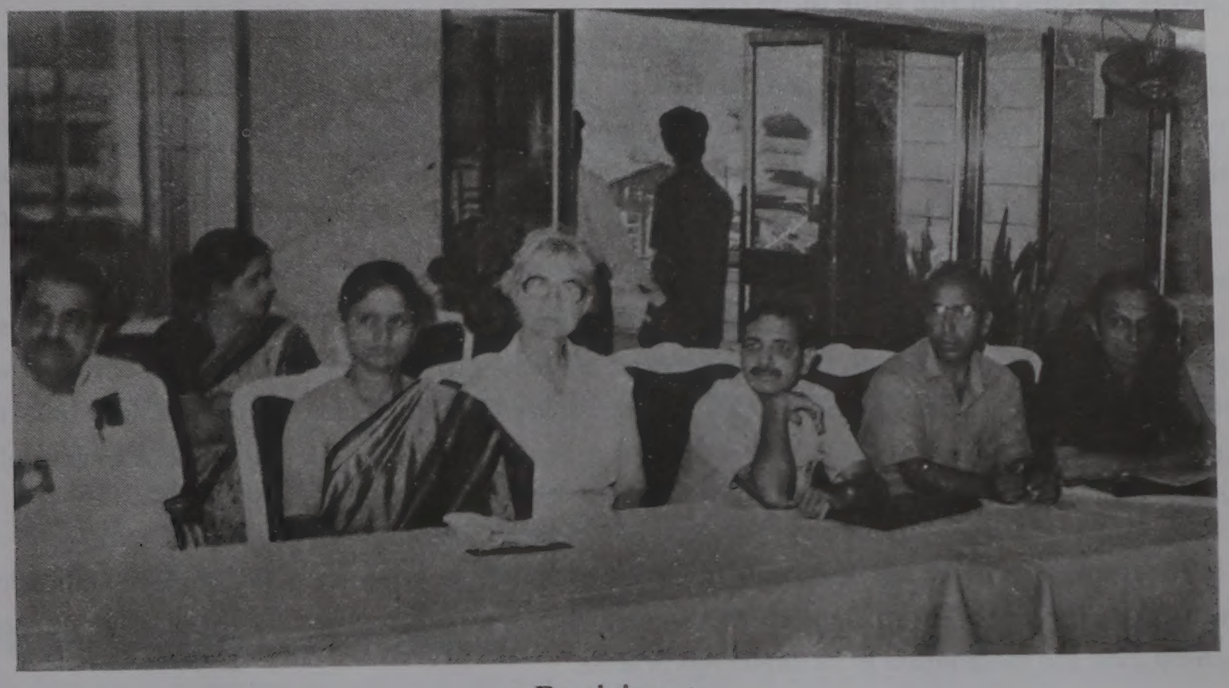
--Policy Formulation - presently made on a ad hoc basis
--Policy Analysis - there is no analyses or debate on major policy issues and intervention.
--Health Planning - is centralized and top down.

--Health research - initiative and does not exact influence on policy makers.

--Policy Implementation - poor.

--Inter sectoral Co-ordination - non existent.

In view of the current situation, the immediate priorities should be the formulation of operational mechanisms for concepts such as community participation, inter sectorial co-ordination and monitoring based on a high risk approach.



Participants

Overview of National Health Policy:

Ms Manisha Khale presented an overview of the NHP. The goal of the NHP is to provide Health For All by 2000 AD through primary health care approach. The main elements of this approach are stated as--

--Linking the provision of comprehensive PHC services with health education and self care.

-- Simple technologies should be transferred to rural based health volunteers.

-- Health infrastructure should be trained to identify, plan and provide preventive, primitive and mental health care facilities.

She stated that the main focus of the Seventh Five Year Plan was reduction in child and material mortality, immunization of children and pregnant mothers, maternal care and reduction in population growth rate by increasing couple protection rate to 60 per cent.

Ms Khale then outlined the measures suggested to achieve the above mentioned priorities.

1. Strengthening existing health infrastructure.
2. Training TBAs.
3. Provision of one female and one male health worker for 5,000 population.
4. Involvement of local communities through community health guides.
5. General development activities.

Group Discussion and Planning Session:

A committee headed by the Joint Director, Health Services Dr. Gandhe divided the participants into three groups. In the view of keeping the group discussion consistent with the objectives of the workshop, terms of reference and guidelines for the discussions were given to the groups.

Accordingly, the participants were divided into three groups and the discussion began at 3.00 p.m. and continued till 5.30 p.m. Again the group discussion continued on April 3rd and went on from 9.30 a.m. till 1.00 p.m.

In the post lunch session there was a presentation of a report by each group before the house and this was followed by a discussion on the recommendations made by them. After these discussions, the necessary changes in the recommendations were made with the permission of the participants.

Planning Session on the Role of NGOs:

During this session MPVHA, Executive Secretary, Mr. Raj Bhujbal gave an overview of the voluntary sector in Madhya Pradesh and expressed his views on the role of NGOs in the effective implementation of NHP. Mr. Bhujbal said that for many years the policy document remained neglected because of a lack of political will to implement the policy and this in turn is due to lack of community participation. The voluntary agencies have a special role to play in mobilizing community for the effective implementation of the policy.

Valedictory Session:

The valedictory function was held in the afternoon of 3rd April, 1990. In this valedictory address the present Director of Medical, Dr. K. L. Simlot Services. Dr. Simlot stressed a need for an effective follow-up for the implementation of the policy. He said that the policy can be implemented by the joint efforts of government and voluntary sector. He however expressed dissatisfaction over the present performance of the voluntary agencies in the field of health.

The participants of the workshop were primarily the officials working at a policy implementation level, ie, district, sector and PHC. Therefore the recommendations put forward by them focus on policy implementation and mechanisms to facilitates this process.

Recommendations

The recommendations are presented in two sections:

1. Policy formulation and
2. Policy implementation.

The recommendations regarding policy implementation are specific and detailed as they outline measures to plug the gaps between policy formulation and implementation.

A. Policy Formulation

A-1 Process of Policy Formulation:

The group was of the opinion that at present policy making is centralised. It does not involve personnel and implementation level personnel which has resulted in a major gap between policy makers and implementors. Therefore, it was recommended that:

The process of policy making should include as adequate representation of all levels of health functionaries ie, PHC, district and division.

A-2 Information Requirements for Policy Formulation:

The group felt that a continuous and consistent flow of information from implementation to policy making levels is a necessary pre-requisite to fulfil information requirements for policy making. They felt that policy makers depend too heavily on sample surveys and selected expert opinion which can sometimes be misleading. Also, the existing information system lacks systematic collection and dissemination. To strengthen the information system at all levels, it was suggested that:

a. Collection of information relevant to policy makers (i.e. vital statistics, infant deaths, maternal deaths, immunization coverage, antenatal cases, malnutrition cases etc.), should be undertaken by

the village health guide (VHG), dai and village health committees.

b. A weekly transfer of information from village to PHC, monthly transfer of information from PHC to district level and district to state level would facilitate a timely flow of information, which could be utilized for policy formulation.

A-3 Policy for Decentralization:

The group stated that although the present policy proposes decentralized planning, there are no clear-cut guidelines to facilitate decentralized planning. The group conceded that targets set at central and state levels do not always correspond to the needs and resources of various areas of operation. The present policy clearly advocates a shift from a hospital cure based approach towards a preventive and promotive approach. However, currently, village level health services are considered the weakest link in the health care system. The group in its various recommendations, suggested that

a. Policy should make provision for planning at various levels (village, PHC, district, division) to ensure effective implementation at these levels.
b. Targets should be set based on needs assessment and available resources.
c. It is necessary to strengthen village level health services, especially the services of trained birth attendants.
d. Motivated village women should be identified and trained to refer cases to PHC.
e. Resources and budgetary allocations should be made available depending on the local needs and demands.

A-4 Policy for Budgetary Allocations:

At present, budgetary allocation is based on a uniform pattern which does not take into account specific health care needs of different areas. This has resulted in planning based on budgetary considerations rather than the health care needs of the area. Therefore the group recommended that:

a. Budgetary allocation should be based on health care needs. Thus, budgetary allocations should be made only after assessing the health situation of the area.
b. Consequent to the above mentioned budgetary allocation, is delegation of power to PHC, block and district level functionaries for utilization of financial resources.

A-5 Policy for Training:

The group felt that - training for health personnel was inadequate and that the curriculum was not linked to performance related knowledge and skills required for programme implementation. The group suggested several recommendations regarding policy related to training. They are:

a. Continuity of the training process at various levels is essential.
b. Training at all level should be task related.
c. Financial resources for training should be made available at the BMO and CMO levels.
d. The focus of training curriculum should be in conjunction with the priorities of health needs.
e. There is need for decentralizing the training process ie, training should be given at all levels - district, sector, PHC and village levels.

A-6 Policy for Health Education:

The group was unanimous in its opinion that health education is almost non-existent. It called for a special emphasis on health education and gave the following recommendations:

a. It is necessary to assess the problems faced while providing health education at a village level.
b. More resources need to be allocated to health education.
c. Alternative and innovative approaches to health education should be explored and strengthened.
d. Topics like planned parenthood should be included within the broader perspective of health

education.

e. Government and NGOs should collaborate in the area of preparation of AV material. Government should also establish a separate cell for the production of AV material.

A-7 Policy for Research:

The group felt that at present, research studies and ongoing programmes are implemented as parallel activities with almost no linkages. This has resulted in minimal impact of research on the effectiveness of on-going programmes. To overcome this situation, the participants suggested:

a. Research should be need based. The massive statistics collected at district and state levels should be analysed.
b. Research should be part of on-going activities. Health personnel at an implementation level should be given an opportunity to undertake research.
c. Research findings should find an immediate translation into programmes.
d. There should be no victimization of personnel if research findings depict an adverse situation.

A-8 Policy for Intersectoral Coordination:

The group stated that the health department conducted its activities in isolation, ie, without co-ordinating with other departments. As a result, there is an over emphasis on immediate causes of ill-health, leaving related environmental causes such as water, sanitation etc., untouched. Such problems can only be resolved through intersectoral co-ordination. The groups suggestion were:

a. A provision should be made in the policy for inter- sectoral coordination at all levels, ie, PHC, district and divisional.
b. Policy should provide for a mechanism to facilitate follow-up of the recommendations of co-ordination committees.

A-9 Policy for Upgrading Infrastructural and other Facilities:

Participants were of the opinion that lack of adequate infrastructural and other facilities was a major obstacle in the implementation of programmes. They also felt that compared to other departments, health is neglected. They recommended that:

a. All sub-centers should be provided with moderate one room building for MPW (F) and MPW (M) with electricity and sanitation facilities. Mass production of prefabricated, standard room which can be fixed on a raised platform was suggested.
b. ANM should be provided with some conveyance e.g. Luna, Bicycle, etc.
c. The transfer policy needs revision.
d. The group felt that there should be a definite promotion policy for both doctors and paramedicals. There also should be a proper posting and transfer policy. At present transfers are made on an ad hoc basis. Promotions should include transfers made from remote to urban areas.

A-10 Policy for Community Participation:

The group pointed out that community participation is very vague and there are no clear cut steps or procedures to involve the community. Therefore, a suggestion was made to form committees at various levels involving representatives from all sections of society. These committees should be involved in the planning, implementation, reporting, and creating demand for services.

B. Policy Implementation

The recommendations on policy implementation provide details on operationalizing mechanisms for implementing various aspects of policy.

B-1 Health Planning:

To facilitate the process of decentralized planning, the participants made specific recommendations related to each level of planning.

a. Village Level Planning:

Village level planning should include selected members of the community, TBA, VHG, MPW(M/F), representatives of voluntary organizations, etc. Planning at village level should include calculation of workload based on surveillance data collected by the dai. Similarly, targets should be fixed based on estimated workload and availability of resources.

b. Sector Level Planning:

Sector level planning should be done once in 3 months. It should include all concerned health personnel and selected village leaders.

c. PHC and District Level Planning:

Planning at the PHC and district level should be done once a year. It should follow the same pattern as at the village and sector level.

d. Community Participation in Planning:

Health Planning Committees including community leaders should be formed it all levels. A pre-requisite for the involvement of community leaders in planning is orienting them to health policy, plan, and strategies.

e. Alternative Strategies/Flexibility of planning:

Within the allocated resources, planners at various levels should be free to attempt alternate strategies for same the objectives. These efforts should be cross analyzed.

f. Financial and Material Resources.

Matching resources, both financial and material should be made to achieve targets.

B-2 Strategy for Policy Implementation:

There was consensus amongst the participants that implementations must be within the 'three tier approach' with the dai and VHG at the village level, MPW (M/F) and supervisors at the middle level and medical officers and other paramedical staff at the PHC level. Following suggestions for policy implementation were made by the group:

a. Village level:

A group of motivated dais and women should be identified and trained in the following - record keeping, antenatal and postnatal care, conducting safe deliveries, health education, identification of common diseases and minor ailment treatment. Regular supply of iron tablets, vitamin A and ORS packets should be made available to VHGs and dais. In tribal districts of Jhabua and Bastar, deliveries are conducted by male dais. They should be identified and trained.

A person can be called a dai if he/she conducts more than 6 deliveries a year.

b. Sub - Center and Sectoral Level:

A female health worker must visit each sub-center atleast once a week or once a fortnight. The male and female health supervisors should visit each village atleast once a fortnight.

Visits should not be on fixed dates but on fixed days, so that VHG and dai are aware of the visits.
Supervisory visits should include monitoring, solving field level problems and guidance.

c. PHC Level:

The medical officers should regularly visit sub-centers. Doctors should function as a team leader. During a sub-center visit, doctors should

-- examine referred cases
-- give guidance to village level workers. There should be no political interference

B-3 Budget Allocation:

BMO should have more powers to allocate resources depending on the needs of the area.

BMO should be given training in financial management.

B-4 Training:

a. Training should equip workers with appropriate skills to do their jobs/tasks. Present training is not task oriented.
b. Dais should be given initial one month's training and there should be provision for in service training at subcenters and periodic training at centers.
c. High risk approach to be included in dais training and training of male and female health workers.
d. One district training center should be established in every district, which should provide 3-5 days need based training to workers at various levels.
e. Impact of training should be evaluated.
f. Every district to have one ideal immunization center where doctors and paramedicals can be sent for training.
g. Training in neonatal resuscitation to be given to BMO, MO, ANM, LHV, and Dai.

B-5 Health Education:

Committees of experts and grass root level workers to be formed at district, PHC, Sector and sub-center level to plan health education activities.

a. Health education can be done at the time of service provision.
b. Health education should be included in school curriculum.
c. Health education messages to be printed on school note books.
d. School children should be involved in health education.
e. Press should be involved in health education by allotting a column on a fixed page every day.
f. It was felt that printed matter is of little use and folk media needs to be used extensively.
g. 'Hat' bazaars can be a good venue for health education.
h. Workers need training for giving health education.
i. Health education methods should give opportunities to people to talk and interact.
j. Fortnightly review of health education activities should be done.
k. Regular KAP studies to assess the impact of health education, should be conducted.

B-6 Research:

Following subject areas were suggested for research:

a. Study of the human factors interfering with or promoting the acceptance of health programmes.
b. Prevalence studies required.
c. Local health problems to be studied.
d. Research findings to be utilized for the future planning.
e. Library facility in each PHC.
f. Books and periodicals should be available at district levels.

g. No victimization on basis of research findings.
h. Publication of research findings in the state periodicals.
i. Facilities for research to be provided.
j. Research activities should not be thrust but done voluntarily.
k. Budget for research at state and district level should be made available.

B-7 Intersectoral Coordination:

a. Co-ordination committee to be formed at the state, district and block level. People from other departments should be involved in the coordination committee.
b. District co- ordination committee with collector as chairman and CMO as secretary. All NGOs, leaders, elected representatives of panchayat, block and district level to be involved.
c. Coordination committee to meet once a month.

B-8 Upgrading Infrastructure and Other Facilities:

a. Appropriate technology such as Talquist paper, BP apparatus etc. should be provided to the ANMs.
b. Facilities at sector and PHC level to be upgraded.
c. PHC doctors to go for anesthesia training.
e. All PHCs should have telephone facilities.

B-9 Facilities for Workers:

a. BMO should be given the status of class I officer.
b. Provision of hostel and other facilities for children.
c. BMO should be a separate cadre.
d. Legal protection for doctors, LBVs and ANMs against
e. Private practice to be abolished. NPA to be increased.

B-10 Record Keeping and Information System:

a. Antenatal cards and registers to be provided at sub- center level.
b. Family folders should be supplied and updated every month.
c. Printed growth cards and registers should be supplied.
d. Dai record book and manual should be supplied to each dai.
e. There should be referral cards at sub-centers, sectors and PHCs.
f. To increase work accountability workers should be given the prepaid post cards with printed health activities, which will be posted from the sub-center to PHC and PHC to districts.
g. All PHCs must have the following equipments -
--Oxygen cylinder, resuscitation trolley, suction machine, Ambu bag, rectal thermometer, endotracheal tubes.
h. There should be a computer at the district level.
i. MPWs should maintain a birth and death register.
j. Village wise information may be displayed at sub-centers.

B-11 Monitoring and Evaluation:

a. Community based Management Information Systems like the one developed for the Universal Immunization Programme by the Institute of Health Management, Pachod, and adopted by the Government of Maharashtra need to be studied for their potential use in Madhya Pradesh.
b. Indicators for monitoring and evaluation need to be developed.
c. Morbidity surveys on lines of polio and tetanus are suggested for other diseases.
d. Inter PHC evaluation to be done once a year.
e. A committee for evaluation at the PHC and district level to be formed comprising of CMO, representative of the NGO and red cross.
f. Training will be required to be able to do qualitative evaluation till then quantitative evaluation should be continued.

Appendix I

LIST OF REGISTERED PARTICIPANTS

A

1. Fr.Thomas Alexander
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44. Dr.A.K.Mishra
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45. Mr.S.S.Mishra
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52. Dr.Ms.S.K.Rokhde
District Leprosy Officer
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53. Dr.R.M.Sahu
Block Medical Officer
PHC Hatod.

54. Mr.D.K.Sharma
District Extention &
Media Officer
Kandwa.

55. Mr.K.C.Sharma
Faculty - Health & Family
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56. Ms.V.Shelar
District Extention & Media Officer
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57. Dr.Mrs.L.Simlot
Chief Medical & Health Officer
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58. Mr.Rajesh Singh
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59. Ms.Subhashni Singh
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60. Dr.Priti Taneja
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61. Fr.Joseph Thayil
Director
Indore Diocesan Social Service
Bishop's House
Indore.

Appendix II

Programme

Venue: Hotel Samrat, Indore

Dates: April 3-4, 1990

April 3, 1990 - Tuesday:

08.30 to 09.15 hrs.	: Registration
09.15 to 11.00 hrs.	: Welcome : Dr. C.S.Gandhe Health Services : Inaugural Speech : Dr. Agrawal, Dean, Medical College : Keynote address-National Health Policy : Existing situation. --Issues of concern of National Western Zone (ie, Maharashtra, Gujarat, MP, Rajasthan and Goa) By Dr. Ashok Dyalchand. : Address-National Health Policy Dr. Inder Bhargava
11.30 to 12.00 hrs.	: Overview of National Health Policy –Focus of 8th Five Year Plan –Goals of Primary Health Care. –Policy formulation to implementation –A framework by Ms Manisha Khale
12.00 to 12.30 hrs.	: Implementation of NHP in MP. - By Dr C S Gandhe, Joint DHS, Indore Divn
12.30 to 13.00 hrs	Gaps in Policy - Possible remedical action –By Dr Ashok Dyalchand & Ms Manisha Khale : Important issue of concern in Primary Health Care and innovative strategies. –By Dr Ashok Dyalchand & Ms Manisha Khale
13.00 to 15.00 hrs	
15. to 17.00 hrs.	: Group discussion Sub: Primary level care for infants –Group I: Immunizable diseases –Group II: Diarrhoeal diseases –Group III: Malnutrition
17.00 to 17.30 hrs.	: Preliminary session –Action plan for infant care

April 4, 1990 Wednesday: 09.30 to 10.30 hrs.	Continuation of plenary session and drafting of resolution.
10.30 to 11.00 hrs	Tea Break
11.00 to 13.00 hrs	: Group Discussion Sub: Primary level maternal and Neonatal Care : Group I: Antenatal Care Services Group II: Deliveries and Postnatal care services Group III: Neonatal care services
13.00 to 14.00 hrs.	: Lunch Break
14.00 to 15.00 hrs.	: Plenary session and drafting of resolutions
15.00 to 15.30 hrs.	: Overview of NGOs in MP –By Mr. Raj Bhujbal
15.30 to 16.30 hrs	: A plenary session of potential contribution of NGOs in implementation of PHC
16.30 to 17.00 hrs.	: Valedictory session Dr. C S Gandhe Jt DHS Indore Divn : Vote of thanks

Areas of Concern:

All the issues will be discussed under the following headings:

i. Infrastructure (Decentralization)
ii. Planning (Decentralization)
iii. Health Education (Decentralization)
iv. Management Information System (Decentralization)
v. Community Participation.
vi. Research requirements.
vii. Monitoring and evaluation.
viii. Intra sectoral co-ordination.
ix. Training

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Published by

M. P. Voluntary Health Association

89/2, Tirupati Colony, Indore, 452001

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